HHA PPS MAILBOX QUESTIONS

VOLUME III: March 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *HHPPSQuestions@HCFA.gov* during the period referenced above. It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at: *www.hcfa.gov/medlearn/refhha.htm.* This batch of questions was pulled from the mailbox prior to April 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

List of Home Health Prospective Payment System (HH PPS) Billing Questions, Volume III, Batch 1:

HH PPS Billing Questions Cross-reference, Volume III, Batch 1:

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General Acronyms

The following acronym may not be spelled out/explained above or elsewhere in this document:

HH = home health
HHA = home health agency
HCFA = Health Care Financing Administration, previous name of the Federal agency administering Medicare. Note: The name of the agency was changed in June 2001 to the Centers for Medicare and Medicaid Services (CMS)
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare claim, placed in Form Locator 44 of Medicare claims
HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims
IPS = Interim Payment System, the legislated system for paying cost-reimbursed home care under Medicare from 1998 until HH PPS

VOLUME III, Batch 1, HH PPS Billing QUESTIONS and ANSWERS

HH PPS and General Policy, Questions:

Home Health (HH) Consolidated Billing:

Q1. Are supplies provided under Medicare A or Medicare B for patients under a HH plan of care?

A1. Supplies are provided under the home health benefit, when the beneficiary is under a HH plan of care. Services under the home health benefit may be paid from the Part A or Part B trust funds, depending upon certain circumstances. If the beneficiary has only Part A or only Part B entitlement, the services are paid from

the corresponding trust fund. For beneficiaries entitled under both trust funds, if the beneficiary enters HH care without a prior three day inpatient hospital stay, the services are paid from Part B. If the beneficiary enters HH care following a three day inpatient stay, the first 100 visits are paid from Part A and any additional visits from Part B. Supplies for an episode are paid from the same trust fund as visits for the same episode.

Q2. If supplies are provided under part B (regardless of whether the patient has Part B), is the HHA bound by traditional Part B coverage requirements and limits?

A2. The HHA is bound by the coverage requirements of the home health benefit.

Q3. If the physician orders a treatment that requires the use of a non-covered supply (i.e. medicated gauze) is this covered under Part A and "included" in the PPS rate or is the beneficiary responsible for payment? If it is "included" how were these costs captured in the $49.62 per episode or $1.94 per visit supply reimbursement?

A3. Only covered home health services and their costs are included in the HH PPS episode rate.

Q4. A home care agency admits a patient who is homebound and requires therapy services. The agency provides the services but before the end of the episode the patient becomes not homebound. His treatment goals have not been met. The patient is discharged from the home care agency because he is no longer homebound. The patient goes to the outpatient therapy department at the hospital and receives further therapy services. Is the home care agency responsible for paying for the outpatient services even though the patient is not homebound? Will the home care agency receive the full episode payment if they are not required to pay for the outpatient services?

A4. The beneficiary is no longer eligible for the home health benefit at the point that he or she is no longer homebound, so the HHA's discharge is appropriate. The HHA's responsibility to pay for the beneficiary's therapy services ends with the discharge of the beneficiary. The HHA will receive the full episode payment unless the beneficiary again becomes homebound and is admitted to another HHA or readmitted to the discharging HHA within the original 60 day episode.

Q5. I need help with some of my outpatient Medicare visits that occur during a home health episode period, according to the Common Working File (CWF). Is there a way when you inquire into the CWF and identify the provider number on an episode that the home health agency can be identified by name? One RHHI has been very helpful, but another refuses to identify the HHA for me since I'm not an HHA.

A5. Identifying health care providers by name in the CWF is restricted by privacy regulations. However, the RHHIs are free to provide this information by phone. Until recently, the Medicare Intermediary Manual and the Home Health Agency Manual referred only to RHHIs giving this information to other HHAs.

HCFA has recently revised these manuals to make it clear that this information must be given to all institutional providers affected by consolidated billing.

Q6. The June 29, 2000 final rule for HH PPS referred to 54 HCPCS codes for therapy services that were subject to consolidated billing requirements. CPT Code 92525 was included in the list of included codes. The HCPCS code G0196, replaced CPT code 92525 as of 1/1/2001 but isn't included in the list. Are home health agencies required to apply consolidated billing regulations to this new code, G0196?

A6. The lists of codes for therapy and non-routine supplies subject to consolidated billing have been updated. New lists of codes subject to consolidated billing effective on or after July 1, 2001 were published in Program Memorandum AB-01-65. Code G0196 is included in the updated lists. Please refer to this Program Memorandum for all the updates. HCFA's Program Memoranda are available at www.hcfa.gov/pubforms/progman.htm.

Q7. We are a provider of therapy services. In the past few months we have been running into problems dealing with Medicare home health patients. I am hoping you can give us some guidance . The following example illustrates the type of problem we are running into.

The patient was referred to us by the physician. We screened for payer sources on admission. The patient informed us in writing there were Medicare, Medicaid and a third party supplemental insurance. There was no home health agency in the information provided by the patient. Since Medicare in this case was primary we submitted the Medicare B bill to our intermediary. We have now been informed by the intermediary that there is a home health episode open during the period we were covering the patient. Our intermediary informed us that they cannot provide information as to what home health agency is involved, only that there is an open home health episode. Finally tracking down the home health agency we have been informed that they are not required to pay for therapy services since we are not associated/contracted with them, they have their own therapists if the patient needed therapy care, and they had told the patient that the patient had to go through them for any services. We have two choices per the home health agency: bill the patient or write off the bill.

We have provided services in good faith to the patient on the physician's order. We were not informed prior to the rendering of services that there was an existing home health episode. We are being denied payment from Medicare due to a home health episode. The home health agency is denying payment due to lack of a preferred provider contract with them. Do we have any recourse through either the Medicare system or dealing with this agency? At this point we are in an untenable position when dealing with home health care. Do you have some way for therapy providers to determine independently if a home health episode is open? Is there any requirement for a home health agency to pay for services rendered by an outside therapy company when we have unknowingly provided care to one of their patients?

A7. You are taking the best first step in asking the beneficiary when providing services if they are receiving services from a HHA or plan to do so in the future. If the answer to this question is yes, then you may also want to determine from the beneficiary which HHA is providing services, and coordinate your services with that HHA. Independent therapy providers may still provide their services under contractual arrangement to a HHA during a HH episode. If an independent therapist has not made a payment arrangement with the HHA, the HHA is not under obligation to the independent therapist. Also, the independent therapist cannot bill the beneficiary for the services.

As an institutional Medicare provider billing an intermediary, you share with home health agencies an eligibility inquiry capability—the HIQH inquiry-- to check in advance if a home health episode has been established for a given beneficiary. However, because the episode is created by the batch processing of a home health request for anticipated payment (RAP) or claim, there may be a lag of a day in between posting the episode and submission of the RAP/claim. A lag is unlikely to occur--under PPS, there is a strong incentive to submit RAPs timely, since they are not subject to the payment floor like claims, and remit 50-60% of the entire 60-day episode payment. The HIQH inquiry will provide you with the provider number of the HHA and, as mentioned in A5 above, all intermediaries must provide the identity of the HHA to all institutional providers.

Q8. If a Medicare Part A home health patient is receiving infusion drug therapy that is not covered under Medicare Part B (i.e., a 14-day course of antibiotic administered via gravity drip), can the infusion pharmacy (a Part B supplier) use the code A9270 to bill the Medicare Part B carrier for denial and then bill the patient's secondary insurance? A9270 is the code for non-covered services; it is not among the codes listed in the Federal Register that must be bundled into the home health episodic payment rate. Similarly, the modifier ZY can also be used in conjunction with certain HCPCS to bill for non-covered supplies. We would like clarification on what effect, if any, home health PPS consolidated billing has on the procedures for "billing for denial" under this method as well.

A8. Home health consolidated billing has no effect on billing processes to Part B carriers regarding non-covered items.

<u>Cost Reporting:</u>

Q9. When filing the yearly HHA cost report under the PPS reimbursement system, if the per visit cost caps are exceeded by the cost per visit on the cost report or if determined Medicare cost exceeds Medicare charges, can either of these adversely affect Medicare PPS reimbursement for the year?

A9. Cost, charge and visit count information for services provided under HH PPS are being collected on the cost report only for use in data analysis about the new payment system. This information will not affect Medicare reimbursement.

The only item under the home health benefit that remains subject to cost settlement is the cost for covered osteoporosis drugs.

OASIS Instructions:

Q10: Can you point me to a place in writing that shows that an OASIS discharge has to be done when a client goes from Medicare to another payer source because the client is no longer eligible for Medicare? I did not find anything on the web site regarding this issue.

A10: An answer to this question was posted to the HCFA website as part of questions and answers regarding the HHABN. The full set of those answers is available at www.hcfa.gov/pubforms/transmit/a0170.pdf. For your convenience, the answer you are looking for is reproduced below:

"What are the OASIS responsibilities when the payer shifts from Medicare to another payer, such as Medicaid? Are these different from when the payer source shifts from non-Medicare such as Medicaid to Medicare? Finally, how should this all be reflected in the OASIS question regarding payer source?"

M0150 of the OASIS data set asks for all current payment sources for home care. As such, it is informational, and not designed for billing purposes. However, in light of PPS, in the OASIS User's Manual on page 8.6, there is guidance relative to OASIS data collection that considers payment source changes. The User's Manual describes the situation where the patient's primary payment source changes from Medicare to an alternative payment source as well as the situation where the patient's primary payment source changes from an alternative payment source to Medicare.

Patient's primary payment sources from skilled home care changes during the episode of care from Medicare to an alternative payment source.

Appropriate Agency Action: There are 2 possibilities for this situation:

1. **If the original start of care (SOC) date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new payment source (or delete any that no longer pertain) in M0150 - Current Payment Sources for Home Care at the next regular assessment.**

2. **If the SOC date changes to coincide with the payment source change, the patient must be discharged (discharge date to coincide with last visit of "old" payment source). A new comprehensive assessment must occur with the new SOC date.**

Patient's primary payment source for home care changes during the episode of care from other-than-Medicare to Medicare.

Appropriate Agency Action: This situation parallels response 2 (above). Follow the

actions described there (i.e., discharge patient on last visit of "old" payment source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source."

HH PPS Claims Submission

Requests for Anticipated Payment and MSP:

Q11. When you are sending in a Request for Anticipated Payment (RAP), how do you let Medicare know that this is Medicare Secondary Payer (MSP)?

A11. Place the appropriate value code on the RAP that identifies the payer that is primary to Medicare for the episode. Value codes and their associated amounts are reported in form locators 39-41 of the UB-92 claim form. The MSP value codes are 12-16, 41-44 and 47. If the primary payer has already made payment for the services in the episode, you may report the payment in the associated amount field. If the primary payer has not made payment, you may report zero in the associated amount field. RAPs indicating MSP will be processed without payment, but will create an episode on the Common Working File (CWF).

Payment Adjustments

Q12. I am the Director of Finance of an HHA. We recently thought we saw something that led us to believe that we would receive full HHRG payment for 4 visit or less cases in the following situations:

--The patient dies before the 5th visit
--The patient is admitted to the hospital and not readmitted to our agency or another agency in the same 60 day episode before the 5th visit
-- The patient is admitted to a nursing home or hospice and not readmitted to any agency in the 60-day episode before the 5th visit
-- The patient is discharged with goals achieved before the 5th visit and not readmitted to an agency before the end of the episode.

Could you please clear this up for us?

A12. If the beneficiary receives four or fewer visits in an episode, the episode is subject to a low utilization payment adjustment (LUPA) in all cases. The episode will be paid on a per-visit basis for the visits that were provided.

Q13. What are we required to bill when a patient has first an increase in care and then a decrease in care in the same episode? The decrease is less than the increase HHRG but not less than the original HHRG. What if it was less than the original HHRG as well as the increase HHRG?

A13. A significant change in condition (SCIC), reflected by a change in the case mix group that results from an OASIS assessment, must be reported on the claim using

two or more HIPPS codes in all cases except when the case mix weight increases and reporting the SCIC would financially disadvantage the HHA.

Q14. Is the outlier threshold prorated or adjusted for SCIC payments? Are all the visits within the episode used for the outlier threshold, regardless of the number of days of service provided?

A14. The outlier threshold is not prorated in the SCIC case or in any other case. The fixed outlier threshold amount (113% of the standard episode payment) is added to the total payment calculated for the episode. This amount is then compared to the costs for all the visits provided in the episode, based on national per visit rates. If the costs are greater than this amount, an outlier payment is calculated. The calculation is the amount the costs are greater than the episode payment plus the threshold amount, multiplied by 80%.

Inpatient Stays Within an Episode:

Q15. We are not certain how we need to bill when a patient has had an inpatient stay during a home health episode. Does the biller need to put anything at all about the dates that the patient was an inpatient? We have also had one patient who had two separate hospitalizations while in an episode. What is the procedure for billing the episode?

A15. Prior to HH PPS, inpatient stays within a billing period were reported using occurrence span code 74. This is no longer necessary under HH PPS. HHAs only need to accurately report the dates of the service visits provided within the episode, ensuring that dates within the inpatient stay are not reported in error. Service dates may fall on the date of admission to the inpatient facility and/or on the date of discharge from the inpatient facility. If the service dates are reported accurately, the HH PPS claim will process regardless of the number of inpatient admissions within the episode.

Q16. Please advise how the following claim should be submitted: A patient was admitted on 10/26/00. The patient was transferred to the hospital on 11/19/00. The Plan of Care goals for the patient were not met. The patient resumed care at the same agency on 12/1/00 and received care through the end of the original episode.

A16. One episode of care should be reflected on the claim, with the claim "From" and "Through" dates (in form locator 6) indicating 10/26/2000 through 12/24/2000. All the services provided both before and after the inpatient admission should be reflected on the claim. If the resumption of care OASIS performed upon the patient's return to home care indicates a significant change in condition (SCIC), which changes the HIPPS code for the episode and requires new physician orders, both HIPPS codes should be reflected on the claim.

Q17. We had a patient that was admitted 12/09/2000 and transferred to a skilled nursing facility on 12/28/00. We did 1 skilled RN visit, 4 aide visits and 4 physical

therapist visits for a total of 9 visits. We billed with a HIPPS code that would indicate we thought we would meet our therapy threshold. Our visits did exceed the 4 visits that would cause the episode to be paid as a LUPA. Would our payment be paid at the HHRG/60 times the number of days (in this example 13 days) the client was on service? Would the transfer to the SNF be considered a partial episode payment (PEP) because of the admission within the 60 days episode?

A17. This episode would not be considered a PEP and therefore the payment would not be prorated on a basis of days. PEPs only result from the transfer of a beneficiary from one HHA to another HHA within the 60-day episode, or from discharge and readmission to the same HHA within the 60-day episode. The payment effect in this case would be that Medicare's Pricer software will downcode the HIPPS code on the claim from a code indicating the therapy threshold is met to the corresponding code indicating the therapy threshold is not met.

Part B Outpatient Services

Q18. A patient has Medicare Part B coverage and is not homebound but requires skilled therapy services. The home care agency is going to provide therapy services under Medicare B. Would this patient fall under PPS and require an OASIS assessment? If not how would the agency bill for these visits under Medicare Part B?

A18. Outpatient therapy visits provided outside of a home health plan of care are not paid under HH PPS. These services continue to be paid under the outpatient therapy fee schedule. These services may be billed to the RHHI using the 34X type of bill in form locator 4 of the claim form, as they were prior to HH PPS. An OASIS assessment is not required in this case.

Claim Coding

Q19. I informed my RHHI that I had a swallowing evaluation, CPT code 92525, that was being rejected because of a home health episode period. The RHHI advised me that their Medical Director has given them direction that the swallowing evaluation was to be filed as an outpatient clinic visit using revenue code 510, not revenue code 440 for speech pathology. Do you think we have our service set up incorrectly?

A19: Yes. The intent of the statute was to bundle speech pathology services into the home health PPS rate. The professional services of a speech pathologist are bundled whether they are provided by a home health agency or under arrangement by another entity. Therefore, it is appropriate to use revenue code 440 for the swallowing evaluation.

Q20. Home health agencies frequently have patients receiving home health care following a hospitalization that involved a cerebrovascular accident (434-436 codes reported by the hospital). Following ICD-9 coding rules, any patient care rendered by a long term care facility (home health, nursing home, rehabilitation) for the resulting

deficits would report the 438 codes (late effect of CVA). The final rule (page 41152) contains a Comment/Response regarding this. The response states "We have not adopted this suggestion. Codes 434 and 436 are being used in home care, not withstanding the coding guidelines. In the Abt case-mix data, episodes coded with 436 are about nine times as common as episodes coded with 438. The definition of 438 encompasses sequelae whose lags may be of any length. For this reason, we believe including 438 presents significant risk of inappropriate payment. We will continue to examine the applicability of code 438 in future work."

What does the above response mean with regard to direction to home health agencies for appropriate coding? If we correctly follow AHA coding guidelines, we would never report a 434-436 and would always report a 438. However, the above statement seems to suggest that for home health, for HCFA/Medicare guidelines, home health agencies are to report 434-436 codes. Since there is no further direction on when to report a 434-436 and when a 438 is more appropriate, are we to infer that 434-436 is, at this point in time, always reported for a home health stay treating CVA deficits? If we always report a 438 based on AHA coding guidelines, we would never receive the 20 points for the neurological diagnostic section linked to the M0230 Oasis item.

The Abt data shows more 434-436 codes because prior to PPS, diagnostic coding did not affect home health care reimbursement; therefore, most home health agencies did not really have full knowledge of ICD-9 diagnostic coding guidelines. Now that coding plays a part in the reimbursement process, it is imperative the agencies know and follow AHA coding rules. If both 434-436 and 438 codes are acceptable in home care, we need a HCFA guideline (maybe based on a specific amount of time after the hospital stay to still report the 434-436 codes?) to determine when we report one or the other, as we cannot randomly assign one or the other without a reason for doing so.

A20: The 436 code is correct for Medicare home health if the patient is in immediate post-stroke home care/rehabilitation, and continues to receive medically necessary treatment and rehabilitation for the stroke. That is, the patient with a recent stroke who continues to improve under rehabilitation therapy should still be considered as recovering from that stroke, and so it would be appropriate to report 436, acute stroke. Once the patient's rehabilitation progress has reached a plateau, then a code from 438 is correct (assuming the patient is still in home care for some reason related to the stroke). There is no time period to guide the selection of a code, because patients' rehabilitation courses vary.

We recognize that 434 and 436 would never appear if agencies followed official guidelines. We did not include 438 among the neurological diagnosis group codes because, under the ICD-9 definition, some patients with that diagnosis are stroke victims experiencing sequelae many years later, and their resource needs would often be different from the needs of an acute stroke patient.

Q21. I am a coding specialist for a home health care agency. I am responsible for setting up coding guidelines/training for our Home Care agencies. A confusing scenario

may be when treating post-amputation wound sites (non-traumatic) and unless the stump or wound is complicated-997.61, 997.62 or 997.69 (see AHA Coding Clinic, 4Q, 96 pg. 46 or Diagnosis Coding Advisor Chapter 17, pg. 151). My understanding is that we should code the reason/disease/condition that necessitated the surgical amputation as the diagnoses, NOT an amputation code from the injury chapter (Amputation, traumatic, by site, multiple codes in range 878-897).

A21: You are correct. One would not use the amputation codes for treatment of a home care patient after a surgical amputation. The amputation codes would only be appropriate in the case of an accidental amputation. Note that if a diabetic patient is primarily receiving home health therapy for an abnormality of gait due to a below-the-knee amputation, the code for abnormality of gait may be the most accurate primary diagnosis. The patient is now missing a leg, and the abnormality of gait may best describe the primary reason for home care (a missing leg).